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Improving Primary Health Care by Strengthening Accountability in the Health Sector

Issue in Brief

Around the world governments face pressures to provide primary health services effectively, efficiently, and equitably. Health reform and health systems strengthening efforts in low- and middle-income countries have adopted similar approaches to getting health systems to perform better: community-based and social insurance, separation of financing and service delivery functions, contracting-out services, decentralization, partnerships, competition in service delivery, performance measurement and indicators, and citizen participation. All these approaches converge in emphasizing accountability as a core element in improving system performance.

The current concern with accountability and primary health care reflects several issues. First is dissatisfaction with health system performance. In developing/transitioning countries, discontent has focused on the high cost, poor quality, limited availability, and inequitable distribution of basic services, coupled with abuses of power, financial mismanagement and corruption, and lack of responsiveness. Policymakers and citizens want health care providers to exercise their professional responsibilities correctly, according to regulations and norms, and with respect for patients. Interestingly, the prevalence and magnitude of corruption in health care systems, which can be viewed as one of the symptoms of weak accountability, has recently been used to explain why well-intentioned health spending may have little or no impact on improving health outcomes (Lewis 2006).

Second, many development banks and donors consider improved accountability essential to ensuring the delivery of basic health services for all citizens, but particularly for the poor and other vulnerable populations. As examples, eligibility for funding from the U.S. government's Millennium Challenge Corporation fundamentally depends on a country's ability to demonstrate accountability and transparency, and the World Bank has provided a strong case demonstrating why weak accountability relationships are key to health care services' failure to serve the needs of the poor.

Third, accountability has become extremely important because specialized knowledge requirements, along with the size and scope of health care bureaucracies in both the public and private sectors, accord health system actors significant power to affect people's lives and well-being.

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Fourth, primary health care constitutes a major budgetary expenditure in all countries, and proper accounting for the use of these funds is a high priority for both governments and donors. This concern takes on increased urgency with the significant influx of global resources for health flowing into some countries.

Further, governments increasingly recognize that health reform efforts designed without an accountability lens can actually hamper health system performance. For example, in some countries, decentralization efforts have led to fragmentation in the financing and management of government-provided primary health care services and confusion as to which level of government is responsible for certain public health functions (Fairbank and Gaumer 2003; Hotchkiss et al. 2005).

All health systems contain different types of accountability relationships, which function with varying degrees of success. For example, health ministries, insurance agencies, public and private providers, legislatures, finance ministries, regulatory agencies, and service facility boards are all connected to each other in networks of control, oversight, cooperation, and reporting. Often their perception that accountability has failed or is insufficient is what furnishes the impetus for change. Strengthened accountability is widely called for as a remedy for health system weaknesses around the world.

Although an awareness of the importance of accountability can help mobilize the demand for change, a guide to the specifics of how to improve health systems is necessary; simply calling for more accountability is not adequate. On the surface, the idea of checks and restraints on power and discretion seems straightforward, but if accountability is to inform action, further analytical and operational work is necessary to assess which strategies work in various country contexts. For example, what works in transitional states may not be successful in fragile states. Often, calls for more accountability are efforts to change the focus and purpose of accountability, rather than simply to do "more of the same" (Romzek 2000: 35). Without sounder conceptual frameworks and more empirically based recommendations, these nuances cannot be sorted out, and accountability risks becoming yet another buzzword in a long line of ineffectual quick fixes, or, worse, a one-size-fits-all bludgeon that encourages excess and overregulation.

This issue of *Insights for Implementers* provides a framework for understanding accountability as it relates to health systems strengthening, a discussion of critical issues that sheds light on the complexities of accountability relationships in the health sector, a tool for assessing accountability linkages, an overview of strategies that can be used to strengthen accountability, and a description of the experience of the Partners for Health Reform*plus* Project (PHR*plus*) in promoting accountability at the country level.

Clarification of Accountability

Although the term accountability is often used in policy discussions of problems that plague health systems, its meaning is often unclear; therefore, it is necessary to clarify what accountability is. The essence of accountability is answerability; being accountable means having the obligation to answer questions regarding decisions and/or actions (Schedler 1999). The following paragraphs examine the components of this definition and provide a simple typology of accountability along with illustrative mechanisms.

Answerability and Sanctions

Two types of accountability questions can be asked. The first type asks simply to be informed; this can include budget information and a narrative description of activities or outputs. This type of question characterizes basic monitoring and implies a one-way transmission of information from the accountable actor(s) to the overseeing actor(s). In democratic governance terms, the informing aspect of answerability relates to transparency.

The second type of question moves beyond reporting information and requests explanations and justifications (reasons); that is, it inquires not just about what was done but why. Justifications incorporate the transformation of information, but go beyond to include dialogue between the accountable and the overseeing actors. This dialogue can take place in a range of venues, from internal to a particular agency (e.g., medical personnel answering to their hierarchical superiors), between agencies (e.g., facilities reporting to health insurance funds), to more public arenas (e.g., parliamentary hearings where health ministers answer to legislators, or community meetings where local health officials answer to residents). Through its contribution to government responsiveness and good governance, the justification aspect of answerability links to the World Health Organization's (WHO) notion of "stewardship" (Travis et al. 2002).

The availability and application of sanctions for illegal, inappropriate, or ineffective actions and behavior uncovered through answerability constitute the other defining element of accountability. The ability of the overseeing actor(s) to impose punishment or withhold rewards (e.g., performance-based incentive payments) from the accountable actor(s) for failures and transgressions gives "teeth" to accountability. Answerability without sanctions is generally considered to be weak.

Most people equate sanctions with requirements, standards, and penalties embodied in laws, statutes, and regulations. Legal sanctions are certainly at the core of enforcing accountability, but sanctions can be thought of more broadly. They include, for example, professional codes of conduct, which do not have the status of law.

They also include an array of incentives that are intended to reward good behavior and action and deter bad behavior and action without necessarily involving recourse to legal enforcement. One category of such incentives relates to the use of market mechanisms for performance accountability. For example, if public health clinics are required to compete for clients on the basis of publicly available information concerning service quality and other aspects of performance, accountability is enforced through the ability of clients to switch from clinics offering poor quality services to those offering high quality. The ability of health clinic users to hold clinics accountable by exercising their exit option creates incentives for responsiveness and service quality improvement (e.g., Paul 1992). In many countries health sector reform seeks to establish these types of incentives.

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Another category of "softer" sanctions concerns public exposure or negative publicity. This creates incentives to avoid damaging the accountable actor's reputation or status. For example, investigative panels, the media, and civil society watchdog organizations use these sanctions to hold government officials accountable for upholding ethical and human rights standards. Self-policing among health care providers is another example of the application of this type of sanction, where professional codes of conduct are used as the standard.

Answerability without sanctions or sanctions without enforcement significantly diminish accountability. Lack of, or selective, enforcement undermines citizens' confidence that government agencies are accountable and responsive, and contributes to the creation of a culture of impunity that can lead public officials to complacency or even to engage in corrupt practices. Enforcement mechanisms are critical, from broad legal and regulatory frameworks, to internal agency monitoring systems, to mechanisms for citizen feedback and participation. A lively debate regarding enforcement concerns the extent to which service delivery markets can be created such that accountability is automatically enforced when poor quality providers are eliminated as a result of purchasers selecting higher quality, more entrepreneurial providers. If the poor lack the purchasing power or physical proximity to access these providers, then socioeconomic disparities in health care utilization rates can widen. Problems arise when actors turn to the legal system as the ultimate arbiter of enforcement, because the courts are subject to political influence or control, and the rule of law is not respected. Problems can also arise when quality standards are enforced by professional associations if those associations are also subject to outside influence.

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Accountability for What?

Defining accountability more precisely requires asking, exactly what are health services accountable for? Three general categories of accountability emerge from answering this question (Brinkerhoff 2001).

- **Financial accountability:** This category represents the most commonly understood notion of accountability. It deals with compliance with laws, rules, and regulations regarding financial control and management, i.e., with the appropriate use of funds.
- **Performance accountability:** This category encompasses public sector management reform, performance measurement and evaluation, and service delivery improvement. It is the effective delivery of services that reflects value for money.
- **Political/democratic accountability:** This category concerns the relationship between the state and the citizens, governance, citizen participation, equity, transparency and openness, responsiveness, and trust building.

Financial Accountability

Financial accountability concerns tracking and reporting on the allocation, disbursement, and utilization of financial resources, using the tools of auditing, budgeting, and accounting. If financial accountability in the health system is weak, corruption is likely to be prevalent. Among the types of corruption that are common in the health sectors are the practice of charging under-the-table payments for health care services; embezzlement; collusion, bribes, and kickbacks in procurement; and diversion and theft of pharmaceutical products at various stages of the distribution system.

The operational basis for financial accountability begins with internal agency financial systems that follow uniform accounting rules and standards. Beyond individual agency boundaries, finance ministries, and in some situations planning ministries, exercise oversight and control functions regarding line ministries and other executing agencies. Because many executing agencies contract with the private sector or with nongovernmental organizations (NGOs), these oversight and control functions extend to cover public procurement and contracting. Insurance fund agencies play a key role in financial accountability in health systems that pay providers for predetermined packages of basic services.

Legislatures pass the budget that becomes the basis for ministry spending targets and for which the ministry is then held accountable. Obviously, a critical issue for the viable functioning of financial accountability is the institutional capacity of the various public and private entities involved. For example, hospitals need to be able to account for the disposition of the funds they receive from various sources if they are to be granted higher degrees of autonomy.

Performance Accountability

Performance accountability refers to demonstrating and accounting for performance in light of agreed-upon targets. If performance accountability is weak, the quality of services and outputs from public agencies and programs is likely to be poor.

Performance accountability is linked to financial accountability in its intent to produce goods, services, and benefits for citizens, but it is distinct in that financial accountability emphasizes procedural compliance, and performance accountability concentrates on results. For example, provider payment schemes that maximize efficiency, quality of care, equity, and consumer satisfaction demand strong financial and management information systems that can produce both financial and performance information. Performance accountability is connected to political/democratic accountability through its performance criteria, which include responsiveness to citizens and achievement of service delivery targets that meet the public's needs and demands.

Political/Democratic Accountability

In essence, political/democratic accountability has to do with the institutions, procedures, and mechanisms that seek to ensure that the government delivers on electoral promises, fulfills the public trust, aggregates and represents citizens' interests, and responds to ongoing and emerging societal needs and concerns. If this type of accountability is weak, communities will lack voice in how health resources are used to meet local health needs.

The political process and elections are the main avenues for this type of accountability. In many countries, health care issues often figure prominently in political campaigns. Building health facilities or providing affordable drugs can be attractive options for politicians attempting to generate electoral support. Beyond elections, however, political/democratic accountability encompasses citizens' expectations of how public officials act to formulate and implement policies, provide public goods and services, fulfill the public trust, and implement the social contract. Policymaking and service delivery relate to aggregating and representing citizens' interests and responding to ongoing and emerging societal needs and concerns. A central issue here is equitable access to quality health services. Government has an important responsibility to remedy health care market failures through both regulation and resource allocation. Poor communities, rural and urban, often suffer from lack of resources; even if government provides fiscal subsidies, facilities and caregivers are frequently scarce or nonexistent.

Political/democratic accountability also relates to building trust among citizens that government is acting in accordance with agreed-upon standards of probity, ethics, integrity, and professional responsibility. These standards reflect national values and culture, and bring ethical, moral, and, occasionally, religious issues into the accountability equation at both the agency and individual levels. For example, in some countries, caring for the sick is a religious duty, and in response, health care providers feel an obligation to deliver services.

Purposes of Accountability

Applying the above classification of accountability types to health services delivery will develop a clearer picture of emerging accountability issues. These issues can then be assessed in terms of three purposes of accountability.

The first purpose is to control the misuse and abuse of public resources and/or authority. This relates directly to financial accountability. The second is to provide assurance that resources are used and authority is exercised according to appropriate and legal procedures, professional standards, societal values (i.e., regarding equity), and community priorities. This purpose applies to all three types of accountability. The third is to support and promote improved service delivery and management through feedback and learning. The focus here is primarily on performance accountability.

Although these three purposes overlap to some extent, in some cases, pursuit of one can lead to conflicts with the other. Perhaps the most recognized tension is between accountability for control, with its focus on uncovering malfeasance and allocating "blame," and accountability for improvement, which emphasizes discretion, embracing error as a source of learning, and positive incentives.

Challenges to Accountability

As observers have noted, there are numerous challenges to achieving these accountability purposes in the health sector.

First, health services are characterized by strong asymmetries among service providers, users, and oversight bodies in terms of information, expertise, and access to services. Regarding information, central oversight bodies can experience difficulties in monitoring provider performance since providers often control the necessary information (Millar and McKevitt 2000).

Concerning expertise, for example, service users "may be ignorant of treatments and medicines that could harm them, and thus need some form of protection" (Shaw 1999: 12). Regarding access, providers can exercise significant gatekeeper power, for example, determining who receives what care, despite official procedures. Health service users, especially the poor, are in a weak position to confront this power.

Second, divergences often exist between public and private interests and incentives, which can constrain efforts to increase accountability (Bennett et al. 1997). For example, Shaw (1999: 12) notes that,

> *"The public and private sector can be sharply distinguished in terms of the speed by which client feedback can affect production, performance, and job tenure. When services are underprovided or of poor quality in the public domain, negative client feedback often takes considerable time, through public opinion polls, media coverage, and eventual changes in political candidates and platforms via the voting process. All this implies a lagged process whereby public administration officials may be misinformed about client demands for some time."*

In the private sector, clients who are dissatisfied with services go to other providers, and this serves as an incentive for providers to improve more quickly. Because at least some components of the health system are likely to remain in the public sector regardless of the ambitiousness of privatization, feedback for accountability can never be as efficient as a fully private model.

Third, institutional capacity gaps often constrain or undermine efforts to measure and increase accountability for all three purposes. The inability of health facility management to track and report on budgets, collect fees, and purchase and inventory pharmaceuticals, supplies, vehicles, and equipment limits the possibilities of accountability for control and assurance. It results in waste in the health system and can create fertile ground for corruption. Further, weak managers who are unable to oversee facility and practitioner performance hamper accountability efforts to improve performance. This capacity gap is aggravated by the difficulty in isolating the contributions of various health system actors to achieving performance goals.

Fourth, the health system comprises a myriad of stakeholders, and, as a result, the process of strengthening accountability is complex. To address accountability and health systems, it is critical to identify and assess the various roles that health sector actors play. The following are stakeholders that should be considered in the process:

- Health service clients
- Ministry of Health
- Agencies of restraint and enforcement (e.g., anticorruption agencies, audit institutions, courts, and law enforcement agencies)
- Funding agencies
- Parliament
- Local government officials
- NGOs
- Health councils and hospital boards
- Professional associations
- Health care providers
- International donors.

Two questions emerge regarding health sector actors with a role in accountability relationships. First, who is accountable? In other words, which actors in the health system are answerable for their actions and behaviors, and are subject to accountability sanctions? Second, to whom are they accountable? That is, which actors have the power, authority, and right to ask for answers and explanations, to engage with the accountable parties in discussion of those answers and explanations, and to impose and enforce sanctions?

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Finally, the objective of improving accountability in health systems may not always be well aligned with the objective of quickly decreasing mortality and morbidity (i.e., reflected in the current focus of the Millennium Development Goals) through increasing access to high-quality primary health care services. Improving accountability is likely to involve health sector reform, which is a long-term process that involves not only defining priorities, refining policies, and consensus building, but also reforming and restructuring institutions through which health policies are implemented (Cassels 1995). While health sector reform is a long-term and challenging process, the rewards in terms of improved health system performance through improved financial, performance, and political/democratic accountability are likely to be immense.

Table 1 presents illustrative health system issues associated with the three types of accountability: financial, performance, and political/democratic. It then identifies the dominant purposes of accountability associated with these issues: controlling abuse, ensuring conformity with standards and norms, and supporting improved performance and learning. This creates a framework for categorizing and taking stock of health system reforms in terms of accountability.

Table 1. Accountability Types, Purposes, and Health Service Delivery

Type of Accountability	Dominant Purposes of Accountability	Illustrative Health Service Delivery Issues
Financial	▲ Control and assurance are dominant. ▲ Focus is on compliance with prescribed input and procedural standards; cost control; resource efficiency measures; elimination of waste, fraud, and corruption.	Separation of purchasing and financing functions Cost accounting/budgeting for: ▲ Personnel ▲ Operations ▲ Pharmaceuticals/supplies ▲ Definition of basic benefits packagess ▲ Contract oversight
Performance	▲ Assurance and improvement/ learning are dominant. ▲ Assurance purpose emphasizes adherence to the legal, regulatory, and policy framework; professional service delivery procedures, norms, and values; and quality of care standards and audits. ▲ Improvement/learning purpose focuses on benchmarking, standard setting, quality management, operations research, monitoring and evaluation.	▲ Patient involvement in medical decision-making ▲ Quality of care ▲ Service provider behavior ▲ Regulation by professional bodies ▲ Provider purchasing (i.e., contracting) ▲ Oversight and supportive supervision
Political/Democratic	▲ Control and assurance purposes are emphasized. ▲ Control relates to citizen/voter satisfaction, use of taxpayer funds, addressing market failure and distribution of services (disadvantaged populations). ▲ Assurance focuses on principal-agent dynamics for oversight; availability and dissemination of relevant information; adherence to quality standards, professional norms, and societal values.	▲ Service delivery equity/fairness ▲ Transparency ▲ Responsiveness to citizens ▲ Service user trust ▲ Dispute resolution ▲ Local needs and priorities

Assessment of Accountability Linkages

Because accountability is a common thread in health systems and in a variety of health systems strengthening and health reform interventions, a focus on accountability can lead to an increased understanding of health system operations, improved design and implementation of interventions, and increased integration of accountability enhancements into the system. A systemic view of accountability acknowledges and highlights the interdependencies among health actors.

Table 2 offers an assessment matrix to map accountability linkages and to examine actors' interactions. The table tracks the patterns of answerability and sanctions in terms of which actors are in a position to demand information and impose sanctions, and which actors are charged with supplying information and are subject to sanctions. The table can indicate situations where there are either two few or too many accountability linkages. Too few linkages can open the door to corruption, lack of responsiveness, poor quality services, and evasion of health service provider responsibility. On the other hand, too many linkages, particularly if they are distant or attenuated connections, can limit the effectiveness of accountability. When many actors and their differing interests are involved, health service provision risks not being sufficiently accountable to anyone. There is no universally "correct" number of accountability linkages. How many linkages are appropriate will, to an important extent, be situation specific, and will depend upon the quality, not simply the number, of connections.

As the code for the table indicates, these supply and demand linkages can be rated as strong, medium, or weak. The downward arrows indicate capacity to demand information and impose sanctions. The horizontal arrows show capacity to supply information and respond to sanctions. Each box may contain two arrows. Effective accountability systems will exhibit a high number of boxes

Table 2. Health Sector Actors Accountability Matrix

Type of Accountability	Demand information, impose sanctions: Health service users/patients	MOH	Agencies of restraint	Funding agencies	Parliament	Local govt officials	NGOs	Hospital boards	Health councils	Professional associations	Unions	Health care providers	International donors
Supply information, respond to sanctions: Health service users/patients	■												
MOH		■											
Agencies of restraint			■										
Funding agencies				■									
Parliament					■								
Local govt officials						■							
NGOs							■						
Hospital boards								■					
Health councils									■				
Professional associations										■			
Unions											■		
Health care providers												■	
International donors													■

Code:
Capacity to supply information and respond to sanctions: Weak →, Medium ⇨, Strong ➔
Capacity to demand information and impose sanctions: Weak ↓, Medium ⇩, Strong ⬇

with both downward and horizontal arrows, indicating that demand for information is adequately met by supply. For example, systems with a preponderance of downward arrows without corresponding horizontal ones suggest several possible problems: mistargeted accountability demand, inadequate response capacity, and/or disagreements over appropriate linkages.

These ratings seek to capture information based on the various actors' capacity to fulfill their accountability roles, the pattern of accountability relationships, and the relative strength or weakness of the accountability chains that connect them. For example, health ministries may have a legal mandate for budgetary oversight of public health facilities' expenditure and collection of user fees, but in many countries their ability to exercise that accountability function is substantially limited (Russell et al. 1999). For a particular country, the matrix can be customized by including the specific array of actors in each of the categories, and/or by tracing the linkages for different types of accountability (e.g., financial versus service delivery performance).

The next steps include identification of issues related to answerability and sanctions, and which type(s) of accountability (financial, service delivery performance, political/democratic) is (are) involved. The mapping exercise informs appraisal of actors' capacity to fulfill

accountability roles, helps to pinpoint gaps, and feeds into setting purposes and targets.

In addition to mapping, applied research can also yield insights into accountability relationships. For example, operations research studies that investigated the impact of a vaccine-preventable disease surveillance system in Georgia revealed that financial roles and responsibilities regarding the investigation of disease outbreaks were unclear (Hotchkiss et al. 2006). This has led to the passage of new public health legislation that corrects this problem.

When undertaken as a team effort, the mapping exercise and applied research can also serve to support the process of planning and implementing activities that aim to achieve performance targets. It can forge consensus among health systems and/or program strengthening team members, as well as point to who else needs to be involved. Strategy implementation will depend upon tapping the shared interests of various actors to build coalitions, commitment, and mutual understanding. Clarifying actors' connections, capacities, and interests is a key input for developing strategies to strengthen accountability.

Strategies to Strengthen Accountability

Despite the increased amount of attention it has received in recent years, accountability (if mentioned at all) is treated as a secondary or corollary dimension in most types of health systems strengthening strategies. The primary objective of these strategies and interventions is typically to improve the accessibility, equity, quality, efficiency, and financial sustainability of service provision. For example, often the rationale used to encourage community participation in health services reform and delivery is to increase targeting of services to the poor, which in turn improves service access, and the rationale for decentralization is to improve alignment of health spending with local needs, which in turn improves service efficiency, access, and quality.

Given that accountability is typically not used as an organizing theme for health systems strengthening interventions and strategies, health policymakers often are not aware of alternative strategies and mechanisms they can use to strengthen accountability relationships in the health sector and how accountability improvements can help to facilitate or enable progress in other health systems strengthening efforts. To help clarify available choices, Table 3 presents a typology of strategies to strengthen accountability. Four types of avenues or strategies are presented: strengthening citizen power/voice; strengthening rules, regulations, and procedures; strengthening management and incentive arrangements; and strengthening health information systems. Each type of strategy is then mapped to both the types of accountability (financial, performance, and political/democratic) and the purposes of accountability (controlling abuse, ensuring compliance with procedures and standards, and improving performance/learning). In practice, efforts to increase accountability are likely to include more than one of these purposes.

Accountability-enhancing strategies can select targets at three different levels: the health system, the facility, and the individual health service provider. System-level interventions could include national health reforms that reinforce or modify the regulatory framework, or that reassign functions among health sector actors, for example, establishing contracting for service delivery, separating payment from provision, or decentralizing pharmaceutical procurement.

As discussed in the previous section, an assessment of accountability linkages might reveal a number of weak accountability relationships involving multiple stakeholders. If accountability-strengthening efforts are to improve health system performance, a strategic approach that draws on a number of instruments and mechanisms may be necessary.

Strengthening citizen power/voice

One source of weak accountability in the health sector relates to the role citizens and clients have in the health system. Particularly where clients have limited power and voice to articulate their needs and demands, the likelihood that the health sector will be accountable to these weaker stakeholders remains low (Bloom 2000). The health care system's inadequate response to community needs may be a result of low household income, cultural barriers, provider bias, and the absence of mechanisms that facilitate community participation. In addition, citizens may be unable to play a role in the broader electoral process and decisions made regarding the prioritization of health needs and the use of government resources to respond to those needs. Their limited power and voice can translate into dysfunctional service delivery relationships between citizens and providers (World Bank 2004). As Anne Mills notes in "Health policy reforms and their impact on the practice of tropical medicine," "the quality and responsiveness to user needs of peripheral health services are likely to be crucially dependent on whether some sense of accountability of health workers to local people can be put in place" (1998: 511).

A number of strategies are available to strengthen citizen power and voice in the health sector. Another instrument to promote consumer power is community-based health financing (CBHF) schemes, which are becoming a frequently used risk-sharing strategy, particularly in sub-Saharan Africa. CBHF schemes are risk pooling organizations that help cover the costs of health care

"Citizen power can be enhanced by expanding the consumer's ability to make a complaint and redress mechanisms to improve the quality of services, and by increasing citizens' purchasing power through the use of vouchers for high-priority health care services."

Table 3. Accountability-Strengthening Strategies and Interventions

Strategy/Intervention	Type of Accountability		
	Financial	**Performance**	**Political**
Strengthen citizen power/ voice ▲ Political participation (e.g., referendum, community boards, bill of rights) ▲ Free popular and scientific press ▲ An increase in household purchasing power ▲ Vouchers, health cards ▲ Community-based programs ▲ Pro-poor coalitions	Control, Assurance	Assurance, Improvement/ Learning	Control, Assurance
Strengthen rules, regulations, procedures ▲ Laws, guidelines, protocols, accreditation, procedures ▲ Independent watchdog committees ▲ Enforcement	Control, Assurance	Assurance, Improvement/ Learning	Ambiguous
Strengthen management and incentive arrangements ▲ Clarification or shortening of chains of accountability ▲ Separation of financing and service provision functions ▲ Addition of provider payment mechanisms (contracting, other mechanisms)	Control, Assurance	Assurance, Improvement/ Learning	Control, Assurance
Strengthen health information systems ▲ Routine health information, including medical records ▲ Disease surveillance ▲ Management information systems ▲ Facility and household surveys ▲ National health accountsData used by citizens, providers, managers, policymakers	Control, Assurance	Assurance, Improvement/ Learning	Control, Assurance

services. By definition, they are managed and operated by organizations other than government and private for-profit companies. The schemes, which are voluntary in nature, aim to increase access to health care by reducing financial barriers. The schemes also attempt to stabilize the incomes of poor people, contribute to resource mobilization for the health sector, and help make public providers more efficient and responsive to consumer needs. PHR and PHR*plus* have provided technical assistance to many of these schemes in Rwanda, Tanzania, Ghana, Senegal, Malawi, and Mali. Preliminary results of studies that have assessed the impact of the schemes in Senegal and Mali suggest that the strategy has resulted in increased use of primary health care services among scheme members.

Consumer power and voice are often particularly weak among the poor in developing countries, resulting in wealth disparities in health outcomes and health care utilization rates. Therefore, accountability strategies must concentrate on improving power and voice among the poor and other vulnerable groups that face substantial barriers to the use of health care services. Among the instruments that are available to strengthen citizen voice are improving the targeting of resources to vulnerable groups and geographical areas and promoting greater participation in the policy making and electoral process (referendums, bill of rights, community boards). For example, in 2004, for the first time in Peru's history, a referendum was conducted to prioritize the health concerns of citizens. Nearly 124,000 residents of Lambayeque region, a mostly rural area in northwestern Peru, cast voluntary, secret ballots to select and prioritize the major health problems that they want targeted in the region's five-year strategic health plan. The referendum was organized by the regional government with PHR*plus* support, and was supervised by Peru's National Electoral Process Office with participation from international observers. The referendum is significant in that the regional government has agreed to incorporate the results in its five-year strategic plan and that the voters included many population groups that are typically excluded from the decision-making process (PHR*plus* April 2005).

"...accountability strategies must concentrate on improving power and voice among the poor and other vulnerable groups that face substantial barriers to the use of health care services."

A free popular and scientific press can also facilitate the strengthening of citizen voice by bringing attention to the government's effectiveness in meeting the needs of the community. For example, in Thailand, the media have played an important role in anticorruption efforts by exposing corruption in the procurement of medicines and medial supplies (Transparency International 2006), and in Albania, the media have exposed egregious examples of the practice of charging informal payments for health services (Vian et al. 2004).

Patients' bill of rights and agency charters exemplify measures to specify provider responsibilities and performance expectations (e.g., Government of Scotland 2001). Community participation in monitoring of service delivery is often used to ensure compliance with standards and to increase grassroots accountability. Pakistan's Family Health Project set up village health committees in Sindh Province, and in several villages the committees created "accountability/vigilance" committees to oversee the finances and operations of rural health facilities and report on problems (Khuwaja 2000).

Strengthening rules, oversight, and compliance

Another broad avenue to accountability enhancement is to strengthen rules, oversight, and compliance. Relative to rules, specific interventions would include the passage of laws and decrees that relate to policies that guide primary health care services, as well as the availability, publication, and dissemination of standards, protocols, and guidelines regarding codes of conduct, financial accounting, and quality of care. Rules alone are unlikely to be effective, however. Strategies must also target compliance with laws, procedures, and standards, with regulation, oversight, monitoring, and reporting requirements in order to strengthen the answerability aspect of accountability. Sources of sanctions include the country's legal framework and judicial system and professional organizations.

A challenge in addressing accountability through compliance is to determine what procedures and standards would improve accountability among actors. At one end of the spectrum are legally and administratively established procedures that are relatively straightforward, particularly for financial accountability. Toward the other end of the spectrum are procedures and standards that require specialized technical expertise both to establish and to monitor, for example, quality of care standards. Issues include the appropriateness of standards, capacity for standard setting and monitoring, and differing performance criteria among various stakeholders.

Other, complementary interventions encompass new organizational mechanisms such as the village accountability/vigilance committees that monitor rural health facilities in Sindh Province in Pakistan (Khuwaja 2000), or the expansion of hospital boards in Capetown, South Africa, to involve community representatives in hospital management (NPPHCN 1998).

Strengthening management and incentive arrangements

The underlying premise in strengthening management and incentive arrangements is that poor incentives are the root of weak accountability in the health sectors; therefore, aligning public policy goals with provider incentives can serve as a powerful force to improve health sector performance. This strategy could

include the following elements: clarifying chains of accountability to determine more precisely who is responsible for what, shortening the chains to make feedback on performance more direct and timely, and making the chains more powerful to increase incentives for responsive performance (e.g., the discipline of the market). The following are some examples of these kinds of strategies:

- Separating financing and service delivery functions to make providers more accountable for service outputs and outcomes
- Increasing the autonomy of hospitals and other types of facilities so that facility performance is more directly tied to the actions of hospital managers
- Introducing provider payment schemes so that monetary incentives are created for better performance and responsiveness to clients

A major tension related to incentive-focused accountability is the pull between allowing actors some degree of discretion to determine the best way to reach performance goals versus requiring actors to follow predetermined rules and modalities. For example, a recent literature review addressing experience with hospital autonomy initiatives in developing countries found that autonomy is typically limited to the handling of user fee revenue collected from the hospital, whereas decisions regarding human resources, including those on the methods used to pay providers, were kept at the central level (Castaño, Bitran, and Giedion 2004). This has limited the effectiveness of autonomy on financial and performance accountability.

Several methodological issues arise in thinking about incentive-based accountability strategies. One has to do with the setting of performance targets and their measurement. In general, these tasks are easier for service delivery, such as health care facilities, than for organizations, such as health ministries, whose outputs are policy related and less tangible. It is also easier for service users to assess performance directly and to hold agencies accountable when the service provided is straightforward and concrete. As noted above, health service users may lack appropriate knowledge and expertise to determine service quality. Another issue has to do with shared accountability and attribution of responsibility (Barrados et al. 2000). For services and activities that cut across several government agencies or involve public-private partnerships, it is difficult to determine who has done what and thus ensuring accountability is often limited. For example, when health service delivery is contracted out to the private sector or NGOs, what happens to the locus of accountability? In addition to this interdependence in producing performance, there is the question of how to deal with environmental factors beyond the control of individual organizations that may affect performance.

Reward and salary structures, employment status, and staff supervision and reporting can significantly impact accountability for individual service providers. For example, in Thailand, hospitals using a capitated rather than a fee-for-service payment mechanism reduced service costs without compromising service quality, which suggests that improvements occurred in financial and performance accountability. This demonstrates that the organizational setting in which providers function strongly conditions individual provider behaviors related to accountability (Yip et al. 2001). In addition, as noted previously, attitudinal factors, professional norms, and ethical or religious values can influence the extent to which individual health service providers feel accountable for the care they offer. For example, a study of health worker motivation in hospitals in Jordan and Georgia found that self-efficacy, pride, management openness, job properties, and values significantly affected motivational outcomes in both countries (Franco et al. 2004).

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Contracting out for primary health care services is a widely used strategy to improve access to and quality of health services through greater accountability. Contracting out combines the use of provider payment mechanisms, performance targets, and provider autonomy. This in turn tightens the link between the actions of facility managers and outcomes. For example, in Egypt, the procedures developed for contracting with the Family Health Fund included incentives and sanctions through a capitation payment mechanism that paid providers prospectively for each individual enrolled, and offered performance-based reimbursements that reward decreased patient waiting time and delivery of preventive care. In Rwanda, community-based health funds build accountability to local communities through the contracts that local health facilities sign with community councils. Capitation payments direct facility managers' attention to patient satisfaction and service quality (Schneider et al. 2001).

Strengthening health information

Health information has been described as the "foundation" of better health in part because of its potential use in promoting accountability in health resources. All of the accountability strategy types previously described depend on the availability of accurate health information. Government has a primary role in this area; one of the hallmarks of democratic governance is information availability and transparency. Data on health needs, health status, health system resource use, and performance must be available and used by stakeholders if accountability relationships are to be more than pro forma or empty exercises in oversight (Bloom 2000). For

example, better informed and educated citizens can make politicians as well as health care providers more accountable, and the government's ability to verify the performance of health care providers is essential to the success of provider payment methods.

Decisions on how health information components should be incorporated into strategy design and implementation should be guided by a conceptual understanding of the role that information plays in strengthening accountability relationships. Important factors include identifying who is responsible for making information available (the supply side) and who will use the information (the demand side), and determining whether and how the information can feasibly be used to promote accountability relationships among stakeholders (answerability). Essential to this process is the government's willingness and ability not only to generate and disseminate these categories of information, but also to promote the use of this information to make stakeholders answerable for inadequate performance levels and unethical and illegal actions. In this sense, the degree of political/democratic accountability, which strongly influences that willingness and availability, is part of the enabling environment for health sector accountability enhancement.

To carry out the functions of health systems, including financing, stewardship service delivery, and resource generation, policy and program managers need access to a variety of information. Sources of information include routine health information systems that provide information on disease surveillance and activities conducted at health care facilities and by health care workers; vital registration systems that provide information on births, deaths, and cause of death; household surveys that provide information on health needs, service utilization patterns, and their socioeconomic determinants; and national health accounts (NHA) that measure health expenditures, including those incurred by the government, private actors such as households, and donors.

Designed to influence a country's health system strengthening process, NHA offers a transparent and consistent way of describing health expenditures by financing sources and uses. It does this by tracking the flow of funds from one health care dimension to another, such as the distribution of funds from the Ministry of Health to each government provider and health service program. A study that examined 21 middle- and low-income countries to determine whether NHA had met its intended purpose found that 19 of those countries had at least one reported instance in which NHA informed the policy process (De et al. 2003). The stages of the policy process NHA influenced included advocacy and policy dialogue, policy formation, implementation, and monitoring and evaluation. For example, NHA in Egypt led to a restructuring of the government's primary health care program in order to better meet the needs of the poor, and NHA in Rwanda led the government to increase HIV/AIDS funding to improve service access. Although the majority of countries studied used NHA, the degree of use depended not only on the nature of the findings, but also on the perception of those findings, particularly by the government. Not surprisingly, if NHA data were perceived to be counter to current political discourse and debate, the NHA report tended to be suppressed in draft form; however, even these draft reports had a subtle effect on health policy.

Development or strengthening of information systems at the facility level can also be important accountability-enhancing interventions. These can include strengthening of financial management, patient tracking and case management, and procurement systems. For example, lack of individualized patient charts, poor medical records, inadequate documentation, and insufficient information flows are often significant impediments to increasing clinical quality assurance and performance accountability. In Albania and Egypt, the Ministry of Health, with PHR*plus* support, developed facility-level management information systems that collected and examined information about clinics. The purpose of the systems is to provide baseline and monitoring data on patient visits and to provide feedback to clinicians concerning practice patterns. To date, several of the clinics have identified important gaps in service use among their covered populations, and have taken steps to remove barriers to promote more appropriate utilization patterns (Gaumer 2005 and PHR*plus* January 2005). In Albania, the health information system was part of a broader primary health care strengthening intervention that significantly reduced the bypassing of health centers in favor of care provided at polyclinic and hospitals (Hotchkiss et al. 2005).

Guidance and Lessons

Almost all health reform and system strengthening interventions are likely to influence, and be influenced by, accountability relationships between key stakeholders. Adopting an accountability lens at the design stage by explicitly establishing accountability objectives can strengthen the chances that strategies will succeed in controlling abuse, ensuring conformity with standards and norms, and supporting improved performance and learning.

The following suggestions and lessons offered to improve accountability are divided by reform stages: design, implementation, and evaluation.

Design

- It is necessary to develop policy frameworks and related structures and procedures that govern the interactions among the various branches and levels of government (e.g., health sector decentralization) and between government and citizens (e.g., the role of elected officials in health service delivery). This will ensure that the reform's focus is not only health

providers, but also the relationships among households, communities, purchasers, providers, and other stakeholders.

- Experience with policy reform, as documented by the PHR*plus* projects (e.g., Gilson 1997, Gilson et al. 1999, Bennett and Paterson 2003) and other USAID-funded analyses (Brinkerhoff and Crosby 2002), shows that demand-driven reforms are more successful and sustainable than top-down technocratic and managerial reforms. The success of accountability-strengthening initiatives depends on the existence of a sufficient demand for accountability.
- International agencies attempting to strengthen accountability in the health sector need to encourage more macro-political and contextual analysis, such as through the health sector actors' accountability matrix and other tools, and recognize the existence of other cultural and political approaches to accountability. For example, in China, the term 'accountability' is almost untranslatable (Standing 2004).
- To strengthen accountability relationships, policy dialogue must involve not only government officials, but an expanded range of stakeholders, including citizen groups, NGOs, for-profit providers, donors, and other actors. This is critical to building consensus among the stakeholders regarding the value of accountability-strengthening investments and to building constituencies for maintaining and expanding financial, performance, and political/democratic accountability.
- Management and health information systems are fundamental to the success of accountability-strengthening strategies. For example, payments in contracting out and voucher programs depend on the verification of provider performance and household health care utilization behavior, respectively, and hospital regulation depends on the verification of management and service delivery processes.

Implementation

- In implementing accountability-strengthening strategies, managers of the reform process should consider developing plans for negotiation, compromise, advocacy, and problem-solving to overcome stakeholder issues; and establishing and enforcing a feedback and decision-making process for using monitoring information to keep accountability-strengthening strategies on track and to make mid-course corrections.
- Where possible and relevant, policymakers should consider pilot testing those reform components that are likely to be most problematic and may need particular consensus (e.g., capitation and provider payment reforms).

Evaluation

- Using the objectives of accountability-strengthening strategies, it is critical to establish a monitoring and evaluation plan. Such a plan should use routine monitoring information in combination with periodic field reviews to assess which strategies are implemented as planned; whether the expected improvements occurred in financial, performance, and political/democratic accountability; and the extent to which the improvements can be attributed to the strategy.
- To avoid unintended consequences, one should deveop a long-term evaluation design that measures the impact of strategies on the major objectives of the program and on more far-reaching health sector objectives within the country.

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